Section 6.1 Submitting Claims and Encounters

6.1.1 Introduction

Upon rendering a covered behavioral health service, billing information is submitted by behavioral health providers as a "claim" or as an "encounter." Some behavioral health providers are reimbursed on a fee-for-service basis (these providers submit "claims") and others are paid on a capitated basis or contract under a block purchase arrangement (these providers submit "encounters"). Regardless of how a provider is reimbursed, the data must be submitted using the same standardized forms.

The intent of this section is to:

- Identify the standardized forms used to submit billing information;
- Provide instructions for completing the standardized billing forms;
- Articulate the timelines for submitting billing information; and
- Provide RBHA specific information for submitting billing information.

6.1.2 References

The following citations can serve as additional resources for this content area:
A.R.S. §36-2904
45 CFR 162.1101
45 CFR 162.1102
9 A.A.C. 34
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/Gila River Health Care Corporation Intergovernmental Agreement
ADHS/Pascua Yaqui Tribe Behavioral Health Program Intergovernmental Agreement
ADHS/DBHS Behavioral Health Services Diagnosis Code Table
ICD-9-CM Manual
First Data Bank Blue Book
Physicians' Current Procedural Terminology (CPT) Manual

Health Care Procedure Coding System (HCPCS) Manual
Co-Payments Section
Third Party Liability and Coordination of Benefits Section
Encounter Validation Studies Section
ADHS/DBHS Office of Program Support Procedures Manual
PM Attachment 7.5.4, Behavioral Health Services Diagnostic Code Table
AHCCCS Fee-for-Service Provider Manual

6.1.3 Scope

To whom does this apply?

All behavioral health providers contracted with a RBHA or TRBHA that submit claims or encounter data.

6.1.4 Did you know…?

The RBHA:

- May be assessed sanctions for noncompliance with encounter submission requirements.
- Must allow claim submission up to six months from the date of service in the absence of a provision establishing a shorter time frame.
- May not pay claims for covered services that are **initially** submitted more than six months after the date of service, or six months after the date of eligibility posting for Title XIX and Title XXI services provided to Title XIX and Title XXI persons, whichever is later.
- Must not pay **clean** claims submitted more than 12 months after the ending date of service or 12 months after the date of eligibility posting for Title XIX or Title XXI services provided to Title XIX or Title XXI persons, whichever is later.
- Must cooperate with providers in the prompt reconciliation of disallowed claims.
- The Arizona Health Care Cost Containment System Administration (AHCCCSA) conducts data validation studies of Title XIX and Title XXI encounter submissions. A data validation study examines a sample of medical records to ensure that the encountered service has actually been provided. ADHS/DBHS or the T/RBHA may also perform data validation studies.
- Submission of legible and accurate billing data facilitates timely reimbursement for fee-for-service providers and the setting of appropriate funding rates for capitated providers.
- A Trading Partner Agreement for Electronic Data Interchange (EDI) transactions must be in place between a RBHA and provider before a provider can submit electronic claims data to a RBHA.

6.1.5 Objectives

To ensure behavioral health providers submit timely, accurate and complete claims and encounter data.

6.1.6 Definitions

Clean Claim

Encounter

Fee-for-Service

Retro-eligibility Claim

Sanction

6.1.7 Procedures

6.1.7-A. What general requirements apply to both TRBHA providers and RBHA providers when submitting claims or encounters?
All paper claims and encounters must be submitted using the CMS 1500, UB-92 or the Universal Pharmacy Form **[RBHA add any other form or format that is used].**

Providers must use the following forms to submit paper claims and encounters:

- PM Form 6.1.1 The CMS 1500 (formerly HCFA 1500) Claim Form is used to bill or encounter most non-facility services, including professional services, transportation and independent laboratories.
- PM Form 6.1.2 The UB-92 Claim Form is used to bill or encounter for all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
- The Universal Pharmacy Claim Form is used by pharmacists to bill or encounter pharmacy services using NDC codes.

All claims and encounters or copies of paper claims and encounters:

- Must be legible and submitted on the correct form.
- Are not considered legible if they contain highlighter or color marks, copy overexposure marks or dark edges (pertains to AHCCCS Tribal RBHA claims only).
- May be returned to the provider without processing if they are illegible, incomplete, or not submitted on the correct form.

HIPAA regulations specify the format for the submission of all electronic claims and encounter submitted to **[Insert Name of RBHA]**.

- HIPAA Format 837P is used to bill or encounter most non-facility services, including professional services, transportation and independent laboratories.
- HIPAA Format 837I is used to bill or encounter for all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services
- HIPAA Format NCPDC is used by pharmacists to bill or encounter pharmacy services using NDC codes.

If more information is needed regarding electronic submission of claims and encounters to **[Name of RBHA]**, please contact **[Enter RBHA contact name and contact information]**.

Behavioral health providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not Title XIX/XXI covered services.

Pseudo identification numbers for Non-Title XIX/XXI eligible persons
Pseudo identification numbers are only applicable to behavioral health providers under contract with a Regional Behavioral Health Authority (RBHA).

On very rare occasions, usually following a crisis episode, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a behavioral health provider may use a pseudo identification number to register an unidentified person. This allows a claim/encounter to be submitted to the RBHA and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- Crisis Intervention Services (Mobile);
- Case Management; and
- Transportation.

Pseudo identification numbers must only be used as a **last option** when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act. For a list of available pseudo identification numbers, see Attachment 6.1.1, Pseudo Identification Numbers.

6.1.7-B. What requirements apply to RBHA contracted providers when submitting claims/encounters?
Behavioral health providers must submit accurate, timely and complete claims/encounter data to the **[RBHA]** for all covered behavioral health services. Dates of service must not span a contract year. Contract years begin on July 1 and end on June 30. If a service spans a contract year, the claim/encounter must be split and submitted in two different date segments, so the dates of service do not span a contract year.

Where are claims/encounters submitted?

Paper claims are mailed to:	**[RBHA billing contact and address]**
Electronic claims/encounters are sent to:	**[Add RBHA process for submitting electronic encounter forms]**

All claims/encounters must be submitted to **[RBHA]** within **[Enter RBHA specific requirement]** from the date of service. Claims/encounters received beyond the **[Enter RBHA specific requirement**], may be subject to timeliness sanctions.

What happens after a claim/encounter is submitted
Submitted claims/encounters for services delivered to a Title XIX or Title XXI eligible person will result in one of the following dispositions:

- Rejected;
- Pended; or

- Adjudicated.

Rejected claims/encounters: Claims/encounters are typically rejected because of a discrepancy between form field(s) and the RBHA's or ADHS'/DBHS edit tables. A rejected claim/encounter may be resubmitted as long as the claim/encounter is submitted within the RBHA's established timeframe **[RBHA enter specific requirement].**

Pended claims/encounters: Claims/encounters may be pended at AHCCCS, or in limited circumstances at ADHS/DBHS. Behavioral health providers must resolve all pended claims/encounters within **[RBHA enter # of days]** of the original processing date. Behavioral health providers must not delete pended claims/encounters as a means to avoid sanctions for failure to correct claims/encounters within the specified number of days. **[RBHA enter any provider expectations for documenting deleted claims/encounters and records of deleted claims reference numbers (CRNs)]**

Each claim/encounter will be subject to disallowance in the event that the claim/encounter is untimely, illegible or incomplete. Any claim/encounter disallowed will be returned by the RBHA to the provider with an explanation for the disallowance.

Adjudicated claims/encounters: Adjudicated claims/encounters have passed the timeliness, accuracy and completeness standards and have been successfully processed by AHCCCS.

What about claims/submissions for Non-Title XIX/XXI eligible persons?
Submitted claims/encounters for services delivered to Non-Title XIX/XXI enrolled persons must be submitted in the same manner and timeframes as described in this subsection.

Claims/encounters for services delivered to Non-Title XIX/XXI enrolled persons will result in one of the following dispositions: Rejected or accepted.

Rejected claims/encounters for services delivered to Non Title XIX/XXI enrolled persons will be returned to the provider with an explanation of the disallowance. A behavioral health provider may resubmit the claim/encounter within the RBHA prescribed timeframe. **[RBHA enter timeframe here]**

6.1.7-C. What requirements apply to TRBHA fee-for-service providers when submitting claims?

All fee-for-service claims must be submitted to the Arizona Health Care Cost Containment System Administration (AHCCCSA) on paper or electronically.

All paper claims must be mailed to:	AHCCCS Claims P.O. Box 1700 Phoenix, Arizona 85002-1700
All electronic claims are submitted to:	Directly to AHCCCS. Contact the AHCCCS Electronic Claims Submission Unit at (602) 417-4242 or (602) 417-4706 or 800-794-6862

The following information is designed to provide an overview of fee-for-service claims submission requirements. All claims must be submitted in accordance with the AHCCCS Fee-for-Service Provider Manual.

Claim submission timeframes
All initial claims must be received by AHCCCS no later than six months from the date of service, unless the behavioral health recipient has retro-eligibility. For hospital inpatient claims, "date of service" means the date of discharge of the behavioral health recipient. Claims initially received beyond the six-month timeframe, except retro-eligibility claims, will be denied. If a claim is originally received within the six-month timeframe, the provider has up to 12 months from the date of service to resubmit the claim in order to achieve clean claim status or to correct a previously processed claim, unless the claim is a retro-eligibility claim. If a claim does not achieve clean claim status or is not corrected within 12 months, AHCCCS is not liable for payment.

What is a retro-eligibility claim?
A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system on the date(s) of service but, at a later date, eligibility was posted retroactively to cover the date(s) of service. Retro-eligibility fee-for-service claims are considered timely submissions if the initial claim is received by AHCCCS no later than six months from the AHCCCS date of eligibility posting. Retro-eligibility claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting. Corrections to paid retro-eligibility claims must be received by AHCCCS no later than 12 months from the AHCCCS date of eligibility posting.

Can a denied claim be resubmitted?
AHCCCS will deny claims with errors that are identified during the editing process. These errors will be reported to the provider in the AHCCCS remittance advice. Providers must correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim timeframe.

When resubmitting a denied claim, the provider must submit a new claim form containing all previously submitted lines. The original AHCCCS claim reference number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission timeframe.

6.1.7-D. Completing The CMS 1500 Claim Form

PM Form 6.1.1- CMS 1500 (formerly HCFA 1500) claim form is used to bill most non-facility services, including professional services, transportation and independent laboratories.

- CPT and HCPCS procedure codes must be used to identify all services.

- ICD-9 diagnosis codes are required to the highest level of specificity and must be coded out to the fourth or fifth digit whenever possible.[1]
- Services billed with DSM-IV diagnosis codes will be denied.

The following instructions explain how to complete the CMS-1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

Field 1. Program Block **Required**
Check the appropriate box or boxes.

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ *(Medicare#)*	☐ *(Medicaid)*	☐*(Sponsor's SSN#)*	☐*(VA File #)*	☐*(SSN or ID#)*	☐*(SSN#)*	☐ *(ID)*

Field 1a. Insured's ID Number **Required**
Enter the person's *AHCCCS ID number*. If you have questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. Behavioral health providers must be sure to enter the client's AHCCCS ID number, *not* the client's CIS number.

1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)
A12345678

Field 2. Patient's Name **Required**
Enter person's last name, first name and middle initial as shown on the person's AHCCCS ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Holliday, John H.

Field 3. Patient's Date of Birth and Sex **Required**
Enter the month, day, and year (MM/DD/YYYY format) of person's birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE			
MM	DD	YYYY	SEX
08	***14***	***1851***	**M** ☒ **F** ☐

Field 4. Insured's Name **Not Required**

[1] Please see the ADHS/DBHS Behavioral Health Services Diagnosis Code Table for a crosswalk of DSM-IV and ICD-9 diagnostic codes.

Field 5. Patient Address **Not Required**

Field 6. Patient Relationship to Insured **Not Required**

Field 7. Insured's Address **Not Required**

Field 8. Patient Status **Not Required**

Field 9. Other Insured's Name **Required if applicable**
If the person has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the person, enter "Same."

Field 9a. Other Insured's Policy or Group Number **Required if applicable**
Enter the group number of the other insurance.

Field 9b. Other Insured's Date of Birth and Sex **Required if applicable**
If the other insured is not the person, enter the month, day, and year (MM/DD/YYYY) of the other insured's birth. Check the appropriate box to indicate gender.

Field 9c. Employer's Name or School Name **Required if applicable**
Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

Field 9d. Insurance Plan Name or Program Name **Required if applicable**
Enter name of insurance company or program name that provides the insurance coverage.

Field 10. Is Patient's Condition Related to: **Required if applicable**
Check the appropriate box.

Field 11. Insured's Group Policy or FECA Number **Required if applicable**

Field 11a. Insured's Date of Birth and Sex **Required if applicable**

Field 11b. Employer's Name or School Name **Required if applicable**

Field 11c.Insurance Plan Name or Program Name **Required if applicable**

Field 11d. Is There Another Health Benefit Plan **Required if applicable**
Check the appropriate box to indicate coverage other than AHCCCS. If "Yes" is checked, you must complete Fields 9a-d.

Field 12. Patient or Authorized Person's Signature	**Not Required**
Field 13. Insured's or Authorized Person's Signature	**Not Required**
Field 14. Date of Illness or Injury	**Required if applicable**
Field 15. Date of Same or Similar Illness	**Not Required**
Field 16. Dates Patient Unable to Work in Current Occupation	**Not Required**
Field 17. Name of Referring Physician	**Required if applicable**
Field 17a. ID Number of Referring Physician	**Not Required**
Field 18. Hospitalization Dates Related to Current Services	**Not Required**
Field 19. Reserved for Local Use	**Not Required**
Field 20. Outside Lab	**Not Required**

Field 21. Diagnosis Codes **Required**

You must enter at least one *ICD-9 diagnosis code* describing the client's condition. Behavioral health providers must **not** use DSM-IV diagnosis codes. Providers must not use code 799.9 (diagnosis deferred) for an encounter or claim. Use the diagnosis code that prompted the visit, which in some instances may be a "V" code. You may enter up to four diagnosis codes in priority order (primary condition, secondary condition, etc.).

Field 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. ***250.52*** 3. _____
2. _____ 4. _____

The information on Fields 22 and 23 are regarding TRBHA Fee-For-Service claims only.

Field 22. Medicaid Resubmission Code **Required if applicable**

Enter the appropriate code ("R" or "V") to indicate whether this claim is a resubmission of a denied claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being voided in the field labeled "Original Reference No."

For ***resubmissions***, enter "R" and the CRN of the denied claim.

Make changes to the appropriate line(s) and submit *all* claim lines for reprocessing. If any lines are blanked out, the AHCCCS system will assume that those lines should not be considered for reimbursement, and any payment made previously will be recouped.

For ***voids***, enter "V" and the CRN of the paid claim. Submit *only* those claim lines to be voided. Cross out lines that are not to be voided.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
R	***20010004321***

Field 23. Prior Authorization Number **Not Required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization

Field 24A. Date of Service **Required**

Enter the beginning and ending service dates in MM/DD/YY or MM/DD/YYYY format. If the service was completed in one day, the dates will be the same. The "To" date must be equal to or prior to the billing date (Field 31).

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From			To						
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
02	***15***	***03***	***02***	***30***	***03***				
or									
02	***15***	***2003***	***02***	***30***	***2003***				

Field 24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.

11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 ER – Hospital
26 Military Treatment Facility
33 Custodial Care Facility
34 Hospice
35 Adult Living Care Facilities
41 Ambulance – Land
42 Ambulance - Air or Water
50 Federally Qualified Health Center
51 Inpatient Psych Facilities
52 Psych Facility Partial Hospitalization
53 Community Mental Health Center
54 ICF/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psych Residential Treatment Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
99 Other Unlisted Facility

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From			To						
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
						11			

Field 24C. Type of Service **Not Required**

Field 24D. Procedure and Procedure Modifier **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals. For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From			To						
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
								90128	***26***

Field 24E. Diagnosis **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference numbers from Field 21 (1,2, 3, or 4), not the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
		1			
		1,2			

Field 24F. Charges **Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
			150.00		
			79.00		

Field 24G. Units **Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT family plan
				2	
				1	

Field 24 H. EPSDT/Family Planning **Not Required**

Field 24 I. Emergency **Required if applicable**
Mark this box with an "X," or a "Y" if the service was an emergency service, regardless of where it was provided.

E	F	G	H	I	J	K
Diagnosis Code	$Charges	Days or Units	EPSDT Family Planning	EMG	COB	RESERVED FOR LOCAL USE
				X		

Field 24 J. COB **Required if applicable**
Check this box for coordination of benefits if there is Medicare or other insurance coverage for the services billed on this line.

E	F	G	H	I	J	K
Diagnosis Code	$Charges	Days or Units	EPSDT Family Planning	EMG	COB	RESERVED FOR LOCAL USE
					X	

Field 24 K. Reserved for Local Use **Required if applicable**
Use this field to report Medicare and/or other insurance information. For Medicare, divide Field 24K with a diagonal or vertical line. Report *Coinsurance* to the *left* of the vertical line or *above* the diagonal line. Report *Deductible* to the *right* of the vertical line or *below* the diagonal line. If a person's Deductible has been met, enter zero (Ø) for the Deductible amount.
If two amounts are reported without a line separating the amounts, the first amount will be considered Coinsurance and second amount will be treated as Deductible. For persons and services covered by third party payer, enter only the amount *paid*.

Always attach a copy of the Medicare or other insurer's EOB to the claim. If the person has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24K. Leaving the field blank will cause the claim to be denied.

E	F	G	H	I	J	K
Diagnosis Code	$Charges	Days or Units	EPSDT Family Planning	EMG	COB	RESERVED FOR LOCAL USE
						175 / 0

Field 25. Federal Tax ID **Required**

Enter the tax ID number and check the box labeled "EIN." If you do not have a tax ID, enter your Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567	☐	☐	

Field 26. Patient Account Number **Required**

This is a number that you have assigned to uniquely identify this claim in your records.

Field 27. Accept Assignment **Not Required**

Field 28. Total Charge **Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT? *(For govt. claims, see back)*	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ Yes ☐ No	$ ***179.00***	$	$

Field 29. Amount Paid **Required if applicable**

Enter the total amount that you have been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts AHCCCS is expected to pay.

Field 30. Balance Due **Not Required**

Field 31. Signature and Date **Required**

The provider or authorized representative must sign the claim. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS *(I certify that the statements on the reverse apply to this bill and are made a part thereof.)*
SIGNED ***John Doe*** DATE ***03/01/02***

Field 32. Name & Address of Facility Where Services Were Rendered
Required if applicable

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
Arizona Hospital **123 Main Street** *Scottsdale, AZ 85252*

Field 33. Provider Name, Address and Phone **Required**
Enter your provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number. Enter the *service* provider's six-digit *AHCCCS provider ID number* and two-digit locator code next to "PIN #." Do not enter more than two digits for locator code. Behavioral health providers must **not** enter their BHS provider ID number.

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
Doc Holliday ***123 OK Corral Drive*** ***Tombstone, AZ 85999***	
PIN # 123456 01	GRP #

Field 33. Provider Name, Address and Phone (Cont.) **Required**
If a group is billing, enter the *service* provider's six-digit AHCCCS provider ID and two-digit locator code next to "PIN #." Enter the *group biller ID* in the "GRP#" field.

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
XYZ Billing Agency ***123 Easy Street*** ***Carefree, AZ 89999***	
PIN # ***123456 01***	GRP # ***654321***

6.1.7-E. Completing the UB-92 Claim Form

PM Form 6.1.2 - The UB-92 Claim Form is used to bill for all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- Revenue codes also must be valid for the bill type on the claim.
- ICD-9 diagnosis codes are required.[2] Diagnosis codes documented on the UB-92 must be in the range of 290.xx through 317.xx for inpatient admissions using an accommodation revenue code.
- DBHS does not accept DSM-IV diagnosis codes, and behavioral health services billed with DSM-IV diagnosis codes will be denied.
- A diagnosis of 799.9, diagnosis deferred, is never acceptable on a UB-92.

The following instructions explain how to complete the UB-92 claim form and whether a field is "Required," "Required if applicable," or "Not required." The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-92*.

Field 1: Provider Data **Required**
Enter the name, address, and phone number of the provider rendering service.

1. **Arizona Hospital** **123 Main Street** **Scottsdale, AZ 85252**

Field 2: Unassigned **Not Required**

Field 3: Patient Control No. **Required**
This is a number that you have assigned to uniquely identify this claim in your records.

Field 4: Bill Type **Required**
Facility type (1st digit), Bill Classification (2nd digit), and Frequency (3rd digit)
See *UB92 Manual* for codes.

2.	3. Patient Control No.	4.Type of Bill
		111

[2] Please see the PM Attachment 7.5.4, Behavioral Health Services Diagnosis Code Table for a crosswalk of DSM-IV and ICD-9 diagnostic codes.

Field 5: Fed Tax No. **Required**

Enter your facility's federal tax identification number. The identification number entered must match the tax ID on your provider record at AHCCCS.

5. Fed Tax No.	6. Statement Covers Period		7. COVD
	From	Through	
86-1234567			

Field 6: Statement Covers Period **Required**

Enter the beginning and ending dates of the billing period in MM/DD/YY or MM/DD/YYYY.

5. Fed Tax No.	6. Statement Covers Period		7. COVD
	From	Through	
	02/15/02	***02/20/02***	
	or		
	02/18/2002	***02/20/2002***	

Field 7: Covered Days **Not Required**

Field 8: Non-covered Days **Not Required**

Field 9: Coinsurance Days **Not Required**

Field 10: Lifetime Reserve Days **Not Required**

Field 11: Group Provider ID **Not Required**

Field 12: Patient Name **Required**

Enter the Person's last name, first name, and middle initial.

12. Patient Name	13. Patient Address
Holliday, John H.	

Field 13: Person's Address **Not Required**

Field 14: Person's Birth Date **Required**

Enter the month, day, and year (MM/DD/YYYY format) of Person's birth.

14. Birthrate	15. Sex	16. MS	ADMISSION			
			17. Date	18. HR	19. TYPE	20. SRC
08/14/1851						

Field 15: Sex **Required**

Enter "M" (male) or "F" (female).

14. Birthrate	15. Sex	16. MS	ADMISSION 17. Date	18. HR	19. TYPE	20. SRC
	M					

Field 16: Marital Status **Not Required**

Field 17: Admission Date **Required**

Required for all inpatient and outpatient claims. Enter the admission date in MM/DD/YY or MM/DD/YYYY format.

14. Birthrate	15. Sex	16. MS	ADMISSION 17. Date	18. HR	19. TYPE	20. SRC
			02/15/02			
			or			
			02/15/2002			

Field 18: Admission Hour **Required**

Required for inpatient and outpatient claims. Enter the code which best indicates Person's time of admission. See *UB-92 Manual* for hour codes.

14. Birthrate	15. Sex	16. MS	ADMISSION 17. Date	18. HR	19. TYPE	20. SRC
				19		

Field 19: Admit Type **Required**
Required for all inpatient claims.

1-Emergency
2-Urgent
3-Elective
4-Newborn

Emergency: Person requires medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.

Urgent: Person requires immediate attention. Claims marked as urgent will not qualify for emergency service consideration.

Elective: Person's condition permits time to schedule services.

Newborn: Person is a newborn. Newborn source of admission code must be entered in Field 20.

Field 20: Admit Source **Required**
Required for all inpatient claims. Enter the code that describes the admission source:

Adults and Pediatrics:
1-Physician referral
2-Clinic referral
3-HMO referral
4-Transfer from hospital
5-Transfer from skilled nursing facility
6-Transfer from another health care facility
7-Emergency room
8-Court/Law enforcement
9-Information not available

Field 21: Discharge Hour **Required**
Required for inpatient claims when the Person has been discharged and all outpatient claims. Enter the code which best indicates the Person's time of discharge. See *UB-92 Manual* for codes.

Field 22: Patient Status **Required**

Required for all inpatient claims. Enter the code that best describes the Person's status for this billing period.

01 Discharged to home or self-care
02 Transferred to another short term general hospital
03 Discharge/Transferred to SNF
04 Discharge/Transferred to ICF
05 Discharge/Transferred to another type of institution
06 Discharge/Transferred to home under care of home health service organization
07 Left against medical advice
08 Discharge/Transferred to home IV provider
09 Admitted as an inpatient to this hospital
20 Expired or did not recover
30 Still a patient
40 Expired at home (hospice only)
41 Expired in hospital, SNF, or ICF (hospice only)
42 Expired, place unknown (hospice only)
50 Hospice - home
51 Hospice - medical facility
61 Discharge/Transferred within this institution to Medicare-approved swing bed
62 Discharge/Transferred to rehab facility including rehabilitation
63 Discharge/Transferred to LTC hospital
64 Discharge/Transferred to a nursing facility certificate
71 Discharge/Transferred /Referred to another institution for outpatient services
72 Discharge/Transferred /Referred to this institution for outpatient services

Field 23: Medical Record No. **Required**

Enter the appropriate medical record number.

Field 24: thru Field 30: Condition Code **Required if applicable**

Enter the appropriate condition codes that apply to this bill. See *UB-92 Manual* for codes.

Field 31: Unassigned **Not Required**

Field 32 thru Field 35: (a-b) Occurrence Code and Date **Not Required**

Field 36: (a–b) Occurrence Span Code and Date **Not Required**

Field 37: Internal Control Number **Not Required**

Field 38: Responsible Party Name and Address **Not Required**

Field 39 thru Field 41: Value Codes and Amounts **Required if applicable**
The following codes are required on claims with Medicare or other insurance. Enter the appropriate code(s) and amount(s). See *UB-92 Manual* for codes.

A1 Medicare Part A Deductible	A2 Medicare Part A Coinsurance
B1 Medicare Part B Deductible	B2 Medicare Part B Coinsurance
C1 Third Party Payer Deductible	C2 Third Party Payer Coinsurance

Field 42: Revenue Code **Required**
Enter the appropriate revenue code(s) that describe the service(s) provided. See *UB-92 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

	42. Rev. Cd.	43. Description	44. HCPCS/Rates
1	***124***		
2	***251***		
3	***258***		
4			

Field 43: Revenue Code Description **Required**
Enter the description of the revenue code billed in Field 42. See *UB-92 Manual* for description of revenue codes.

	42. Rev. Cd.	43. Description	44. HCPCS/Rates
1	***124***	**Psych Stay/2 beds**	
2	***251***	***Drugs/Generic***	
3	***258***	***IV Solutions***	
4			

Field 44: HCPCS/Rates **Required if applicable**
Enter the inpatient accommodation rate and appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes. Providers must enter the appropriate CPT/HCPCS code when billing for outpatient services.

	42. Rev. Cd.	43. Description	44. HCPCS/Rates
1	***124***	***Psych Stay/2 beds***	***1,088.00***
2	***251***	**Drugs/Generic**	***85595***
3	***258***	***IV Solutions***	***95900***
4			

Field 45:Service Date **Not Required**

Field 46: Service Units **Required**

If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the Person has been discharged, the admission date is covered to, but not including, the discharge date. Accommodation days reported must reflect this. If the Person expired or has not been discharged, the admission date through last date billed is covered.

46. Serv. Units	47. Total Charges		48. Non-Covered Charges		49.
2	*2000*	*00*			
3	*350*	*50*			
1	*150*	*25*			

Field 47: Total Charges By Revenue Code **Required**

Total charges are represented by revenue code 001 and must be the last entry in Field.

Total charges on one claim cannot exceed $999,999,999.99.

	42. REV. CD.	43. DESRIPTION	44. HCPCS RATES	45. SERV. DATE	46. SERV. UNIT	47. TOTAL CHARGES	
1	*124*	*Psych Stay/2 beds*			*2*	*2000*	*00*
2	*251*	*Drugs/Generic*			*3*	*350*	*50*
3	*258*	*IV Solutions*			*1*	*150*	*25*
4	*001*	*Total Charge*				*2500*	*75*

Field 48: Non-covered Charges **Required if applicable**

	46. SERV. UNITS	47. TOTAL CHARGES		48. NON-COVERED CHARGES		49.
1	*2*	*2000*	*00*	*100*	*00*	
2	*3*	*350*	*50*	*50*	*00*	

Field 49: Unassigned **Not Required**

Field 50(A–C): Payer **Required**

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the person and from whom the provider might expect some reimbursement.

	50. Payer	51. Provider No.	52. REL INFO		53. ASG BEN
A	**Blue Cross**				
B	***ADHS/DBHS***				
C					

Field 51(A–C): Provider No. **Required**

Enter your facility's ID number as assigned to you by the payer(s) listed in Fields 50 A, B, and/or C.

	50. Payer	51. Provider No.	52. REL INFO		53. ASG BEN
A	***Blue Cross***				
B	***ADHS/DBHS***	***654321***			
C					

Field 52(A–C): Release of Information **Not Required**

Field 53(A–C): Assignment of Benefits **Not Required**

Field 54(A–C): Prior Payments **Required if Applicable**

Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer listed in Field 50. If the Person has other insurance but no payment was received, enter "Ø." The " Ø " indicates that a reasonable attempt was made to determine available coverage and obtain payment.

Field 55(A–C): Amount due **Not Required**

Field 56: Unassigned **Not Required**

Field 57: Unassigned **Not Required**

Field 58(A–C): Insured's Name **Required**
Enter the name of insured (AHCCCS Person) covered by the payer(s) in Field 50.

	58. Insured's Name	59. P.Rel.	60. Cert.-SSN-HIC.-ID No
	Holliday, John H.		

Field 59(A–C): Patient's Relationship To Insured **Not Required**

Field 60(A–C): Patient CERT. - SSN – HIC – ID NO. **Required**
For Title XIX or XXI Person's providers must be sure to enter the Person's AHCCCS ID number

For Non-Title XIX or XXI Persons providers must enter the Person's BHS number.

	58. Insured's Name	59. P.Rel.	60. Cert.-SSN-HIC.-ID No
	Holliday, John H.		A12345678

Field 61(A–C): Group Name **Required**
Enter "FFS" for AHCCCS IHS and ESP Persons.

Field 62(A–C): Insurance Group Number **Not Required**

Field 63(A–C): Treatment Authorization **Not Required**

Tribal Fee For Service Claims only: The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization.

Field 64(A–C): Employment Status Code **Not Required**

Field 65(A–C): Employer Name **Not Required**

Field 66(A–C): Employer Name **Not Required**

Field 67: Principal Diagnosis **Required**
Enter the principal *ICD-9 diagnosis code*. Providers may **not** use DSM-IV diagnosis codes.

67. Prin. Diag Code	Other Diag. Codes							
	68. Code	69. Code	70. Code	71. Code	72. Code	73. Code	74. Code	75. Code

Field 68–75: Other Diagnosis **Required if applicable**
Enter other applicable ICD-9 diagnosis codes. Include codes for other conditions that existed during the episode of care but were not primarily responsible for admission.

Field 76: Admitting Diagnosis **Required if applicable**
Required for inpatient bills. Enter ICD-9 diagnosis code that represents the significant reason for admission.

Field 77: E-Codes **Required if applicable**
Enter trauma diagnosis code, if applicable.

Field 78: DRG **Not Required**

Field 79: Procedure Method **Not Required**

Field 80: Principal Procedure Code and Dates **Required if applicable**
Enter the principal ICD-9 procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires highest skill level.

Field 81: Other Procedure Codes **Required if applicable**
Enter other procedure codes in descending order of importance.

Field 82: Attending Physician **Not Required**

Field 83: Other Physician **Not Required**

Field 84: Remarks **Required if applicable**
Required on resubmissions, and voids. Enter the CRN of the claim being resubmitted, or voided. For resubmissions of denied claims, write
"Resubmission" in this field.

Field 85: Provider Representative **Required**
An authorized representative must sign each claim form verifying the certification statement on reverse of claim. Rubber stamp or facsimile signatures are acceptable but must be initialed by a provider representative.

85. Provider Representative	86. Date
Betsy Ross	
I Certify The Certifications on the Reverse Apply To this Bill and Made a Part Hereof.	

Field 86: Date **Required**
Enter the date the claim is submitted in MM/DD/YY or MM/DD/YYYY format.

85. Provider Representative	86. Date
Betsy Ross	**03/15/03 or 03/15/2003**
I *Certify The Certifications on the Reverse Apply To this Bill and Made a Part Hereof.*	

6.1.7-F. Completing the Universal Claim Form

Pharmacists use The Universal Claim Form to bill for pharmacy services using NDC codes. Pharmacy personnel fill out this form and send it to the T/RBHA or T/RBHA's pharmacy benefits manager.

The following instructions explain how to complete the Universal Claim Form and whether a field is "Required," "Required if applicable," or "Not required."

Field 1:Group No. **Not Required**

Field 2:Cardholder I.D. No. **Required**
For Title XIX or XXI eligible Persons, providers must be sure to enter the Person's AHCCCS ID number

For Non-Title XIX or XXI eligible Persons, providers must enter the Person's BHS number.

Group No. ☐		Cardholder I.D.No.	**2345678**

Field 3:Cardholder Name **Required**
Enter the Person's last name, first name, and middle initial. This must be the name of the patient for whom medications or supplies were dispensed.

Card-Holder Name	***Holliday***	***John***	**R**	Other Third Party Coverage ☐ Yes ☐ No
	Last	First	Initial	

Field 4:Other Third Party Coverage **Required**

Check appropriate box to indicate whether the Person has third party coverage.

Card-Holder Name	Last	First	Initial	Other Third Party Coverage
	Holliday	***John***	**R**	☐ Yes ☐ No

Field 5: Patient Information **Required**

Enter the Person's last name, first name, middle initial; date of birth (if available), sex; and relationship to the cardholder.

Patient Last Name	First & Initial	Date of Birth			Sex		Relationship To Cardholder			
		MO	Day	YR	M	F	Card Holder	Spouse	Child	Other
Holliday,	***John R.***	***07***	***04***	***65***	***X***					

Field 6: Pharmacy Information **Required**

Enter the name, street address, city, state, and zip code of the provider who dispensed the medication or supplies.

Pharmacy Information	
Name	***John Doe, MD***
Street No.	***123 Main Street***
City, State, & Zip	**Scottsdale, AZ 85252**
Pharm No.	
Phone	

Field 7:Pharmacy Number **Required**

Enter the assigned Pharmacy ID number and the two-digit locator code.

Pharmacy Information	
Name	**John Doe, MD**
Street No.	***123 Main Street***
City, State, & Zip	**Scottsdale, AZ 85252**
Pharm No.	**333333 00**
Phone	

Field 8: Phone **Not Required**

Field 9: Date Rx Was Written **Required**

Enter the date of the prescription as MM/DD/YY or MM/DD/YYYY.

Date RX(s) Written		
MO	Day	YR
09	***15***	***03***
Date RX(s) Filled		
MO	Day	YR

or

Date RX(s) Written		
MO	Day	YR
09	***15***	***2003***
Date RX(s) Filled		
MO	Day	YR

Field 10: Date Rx Was Filled **Required**

Enter the date of service for this billing as MM/DD/YY or MM/DD/YYYY format. If the prescription is a refill, the date of refill should be entered.

Date RX(s) Written		
MO	Day	YR
09	***15***	***03***
Date RX(s) Filled		
MO	Day	YR
09	***15***	***03***

or

Date RX(s) Written		
MO	Day	YR
09	***15***	***2003***
Date RX(s) Filled		
MO	Day	YR
09	***15***	***2003***

Field 11: Rx Number **Required**

Enter the first prescription number.

RX Number	New Refill	Metric Quantity	Days Supply
99-12345			

Field 12: New or Refill **Required**

Enter "N" if claim is new, "R" if it is a refill.

RX Number	New or Refill	Metric Quantity	Days Supply
	R		

Field 13: Metric Quantity **Required**

Enter the quantity provided.

RX Number	New Refill	Metric Quantity	Days Supply
		21	

Field 14: Days Supply **Required**

Enter the number of days the prescription is expected to cover.

RX Number	New Refill	Metric Quantity	Days Supply
			7

Field 15: National Drug Code **Required**

Enter the labeler number, product number, and package number for the items dispensed. All 11 digits, including any leading zeros, must be entered on the claim form.

National Drug Code			Prescriber Ident.	DAW
Labeler No.	Product No.	Pkg.		
00001	***2345***	***67***		

Field 16: Prescriber Ident. **Required if applicable**

Required for all Tribal Fee For Service claims. The Tribe must enter its TRBHA identification number in this field.

National Drug Code			Prescriber Ident.	DAW
Labeler No.	Product No.	Pkg.		
			654123	

Field 17: DAW (Dispense As Written) **Required**

Indicate whether the prescribing provider required a brand name drug by entering "1." If generic items were allowed, enter "0."

National Drug Code			Prescriber Ident.	DAW
Labeler No.	Product No.	Pkg.		
				0

Field 18. Ingredient Costs **Required**
Enter the cost of the ingredients of dispensed items.

See Signature Log	**$32**	**50**	Ingr. Cost
			Disp. Fee
			Tax
Authorized Pharmacy Representative X			Total Price
			Ded. Amt.
			Bal

Field 19: Dispensing Fee **Not Required**
Not required. The dispensing fee is systematically added by the AHCCCS system.

Field 20: Tax **Not Required**
Do not enter sales tax amounts. AHCCCS is exempt from payment of sales tax.

Field 21: Total Price **Required**
Enter the sum of the components' cost (not including dispensing fee).

See Signature Log	**$32**	**50**	Ingr. Cost
			Disp. Fee
			Tax
Authorized Pharmacy Representative X	**$32**	**50**	Total Price
			Ded. Amt.
			Bal

Field 22: Deductible Amount **Required if applicable**
Enter the amount of any third party payments received. If the third party payer was billed and the claim was denied or no payment resulted, enter “0.” The “0” indicates that a reasonable attempt was made to determine available coverage and collect for the service provided.

Field 23: Balance **Not Required**

Field 24: Authorized Pharmacy Representative **Required**
An authorized representative of the pharmacy must sign and date the claim. Rubber stamp signatures are acceptable but must be initialed by a provider representative.

Fee-For-Service Provider Manual

IMPORTANT: The links below lead to individual files in **PDF** format. You may download them individually, or click here to download them all in a 2.9MB **ZIP** compressed file archive.

Chapter 26: **Correcting Claim Errors** (146KB)

- Exhibit 26-1, Claim Correction Request Form (49KB)
- Exhibit 26-2, Claim Status Request Form (49KB)

Chapter 27: **Understanding the Remittance Advice** (190KB)

- Exhibit 27-1, Sample Remittance Advice - Address Page (70KB)
- Exhibit 27-2, Sample Remittance Advice - Financial Summary (80KB)
- Exhibit 27-3, Sample Remittance Advice - Paid Non-Facility Claims (81KB)
- Exhibit 27-4, Sample Remittance Advice - Denied Non-Facility Claims (81KB)
- Exhibit 27-5, Sample Remittance Advice - Adjusted Non-Facility Claims (81KB)
- Exhibit 27-6, Sample Remittance Advice - Voided Non-Facility Claims (81KB)
- Exhibit 27-7, Sample Remittance Advice - Non-Facility Claims in Process (80KB)
- Exhibit 27-8, Sample Remittance Advice - Processing Notes (80KB)
- Exhibit 27-9, Sample Remittance Advice - Paid Facility Inpatient Claims (81KB)
- Exhibit 27-10, Sample Remittance Advice - Paid Facility Outpatient Claims (81KB)
- Exhibit 27-11, Sample Remittance Advice - Denied Facility Claims (80KB)
- Exhibit 27-12, Sample Remittance Advice - Adjusted Facility Claims (81KB)
- Exhibit 27-13, Sample Remittance Advice - Voided Facility Claims (80KB)
- Exhibit 27-14, Sample Remittance Advice - Facility Claims in Process (80KB)

Chapter 28: **Claim Disputes** (55KB)

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